



GP REFERRAL FORM FOR RESIDENTIAL MEDICATION MANAGEMENT REVIEW (903)

**GP to attach relevant clinical documentation.*

Date: / /

Referral from:	Doctor Name:	Phone:
	Address:	Fax:

Referral to:	Pharmacist Name:	Phone:
	Address:	Fax:

Resident name:	Medicare number:
Address:	Pension number:
DOB: Age: Sex:	Record number:

Resident's verbal consent for RMMR obtained: <input type="checkbox"/> Yes
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Dear (insert Pharmacist's name),

Thank you for seeing this resident whom I believe requires an RMMR for the following reason:

- Resident taking 5 or more regular medications
- Residents taking more than 12 doses of medication per day
- Residents suffering from multiple (3 or more) medical conditions
- Discharge from an acute care facility in the previous 4 weeks
- Significant changes made to medication treatment regime in the last 3 months
- Change in medical conditions or abilities (including falls, cognition, physical function)
- Medication with a narrow therapeutic index or medication requiring therapeutic monitoring
- Symptoms suggestive of an adverse drug reaction
- Sub-therapeutic response to treatment
- Suspected non-compliance or problems managing medication related therapeutic devices
- Risk of inability to continue managing own medications (e.g due to changes with dexterity, confusion or impaired sight)
- Other: _____

(Agreed criteria above from Comprehensive Medication Review in Residential Aged Care Facilities, p. 99, Nov 2002).

Relevant clinical information is included to assist with your review. I look forward to receiving your report.

Proposed review date: / / (GP and reviewing pharmacist)

Regards,

GP signature: _____ Date: _____

Copy of this referral to: Resident's medical file